COLORADO
Department of Public Health & Environment

To: Members of the State Board of Health

From: Diana Herrero, Division of Disease Control and Public Health Response Deputy Director ***DH***

Amanda Hettinger, Office of Emergency Preparedness and Response Director, Division of Disease Control and Public Health Response (DCPHR) ***AH***

Through: Scott Bookman, Division of Disease Control and Public Health Response Director ***SB***

Date: February 15, 2023

Subject: Emergency Rulemaking Hearing concerning 6 CCR 1009-5, Preparations for a Bioterrorist Event, Pandemic Influenza, Or An Outbreak By A Novel And Highly Fatal Infectious Agent Or Biological Toxin

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Find copies of the following documents: Statement of Basis and Purpose and Specific Statutory Authority, Regulatory Analysis, Stakeholder Engagement, and Proposed Amendments to 6 CCR 1009-5, Preparations for a Bioterrorist Event, Pandemic Influenza, Or an Outbreak by a Novel and Highly Fatal Infectious Agent Or Biological Toxin.
The Colorado Department of Public Health and Environment (Department) has the legal authority, established in Colorado law, to adopt rules and establish standards to assure that hospitals, other acute care facilities, county, district, and municipal public health agencies, and trauma centers are prepared for an emergency epidemic, as defined in section 24-33.5-703 (4).

Prior to the COVID-19 pandemic, no routine or reliable healthcare data existed either as a baseline capacity measure or long-term trend analysis to effectively measure the status of Colorado's ability to provide adequate healthcare during crisis events. In the spring and summer of 2020 during the first COVID-19 surge, the Department introduced more than 1,300 healthcare facilities to a statewide and voluntary situational awareness reporting platform (EMResource). Access to this new data from facilities across the state enabled the Department to track healthcare surge for hospitals, emergency management services (EMS), and long-term care facilities. The Department transformed the data using visualization and informatics tools to provide a one-stop comprehensive website and resource for decision-makers across Colorado's communities. The timely value and critical importance of this voluntarily reported data were reinforced by the requirements set forth in Public Health Order 20-38 (PHO20-38).

During the course of the COVID-19 pandemic, these rules (6 CCR 1009-5) were augmented by requirements delineated in PHO 20-38. This public health order was enacted on April 15, 2021, and is set to expire in February 2023. PHO 20-38 addresses explicitly the Department's need for hospitals to report their hospital bed capacity data regularly and continuously. The proposed language to be moved from PHO 20-38 into 6 CCR 1009-5 includes the following:

- The daily maximum number of adult and pediatric beds that are currently or can be made available within 24 hours for patients in need of ICU level care;
- The daily maximum number of all staffed acute care beds, including ICU beds, available for patients in need of non-ICU hospitalization; and
- The daily maximum number of all adult and pediatric med/surgical beds, available for patients in need of non-ICU hospitalization.

This hospital bed capacity data is used to drive decision-making by local, regional, and state public health agencies, as well as policymakers, including the Governor's office. With its partners, the Department used this data to develop and monitor critical threshold triggers for bed capacity, resource shortages, and staffing challenges. The impact of patient surge on rural healthcare delivery, statewide EMS transport, and critical access hospitals was monitored and communicated to key stakeholder groups and leaders in the public health and medical systems. These daily reporting metrics supported the Combined Hospital Transfer Center activation as one of Colorado's most successful patient load-balancing mitigation strategies for effective transport and transfer capacity of patients across the state and now represents a national best practice.

In addition, the Colorado legislature passed House Bill 22-1401 (HB 22-1401), *Hospital Nurse Staffing Standards*, during the 2022 legislative session. This new law sought to ensure hospitals are prepared for a public health emergency or staffing shortage by implementing a robust nurse staffing committee and plan, comprehensive emergency management, and reporting on staffed-bed capacity data to the Department. HB 22-1401 required the Board of Health to promulgate rules by September 1, 2022; emergency rules were adopted and became effective on August 17, 2022, again on November 16, 2022, and will remain in effect for one hundred twenty (120) days. These rules were promulgated into existing rule sets that regulate hospitals across the state (6 CCR 1011-1, Chapter 4). As the Department continues to work through the stakeholder process, it was determined that the regulations related to hospital bed capacity reporting requirements should be located in one rule set.

Thus, the Department proposes moving part of these emergency rules into 6 CCR 1009-5, Preparations for a Bioterrorist Event, Pandemic Influenza, or an Outbreak by a Novel and Highly Fatal Infectious Agent or Biological Toxin. The proposed rule language to be moved from 6 CCR 1011-1, Chapter 4 into 6 CCR 1009-5 includes the following:

- The definition of staffed-bed capacity; and
- Requirements for hospitals to:
    - Report to the Department the hospital's current staffed-bed capacity, in a form and manner determined by the Department;
    - Notify the Department if the hospital's ability to meet staffed-bed capacity falls below 80% of the required baseline in a specified period and submit a plan to staff the hospital at 80% or above of its staffed-bed capacity within thirty (30) days.

By pairing the data required by HB 22-1401 with the data collection elements from PHO 20-38, hospitals will be able to refer to one rule set for a comprehensive understanding of the hospital bed capacity data they are required to report to the Department for emergency preparedness and response purposes.

In order for the current emergency rules required by HB 22-1401 to remain effective while the Division of Disease Control and Public Health Response (DCPHR) works through its stakeholder

engagement process, another set of emergency rules must be adopted by the Board of Health in February 2023.

Regarding HB 22-1401, the Department began a robust stakeholder process in September and has held four meetings thus far. An average of 87 people attended each meeting. The Divisions of Health Facilities and Emergency Medical Services and DCPHR will continue to work with stakeholders during this transition of rule language and until the rule language becomes permanent. During this time, the Department will maintain the process for hospital reporting in a manner consistent with hospital reporting to the Department throughout the entirety of the COVID-19 pandemic, pursuant to PHO 20-38.

In total, the Department requests an emergency rulemaking so that the requirements established in PHO 20-38 and HB 22-1401 are promulgated into the rule, effective immediately.

Changes to rule language appear in ALL CAPS, highlighted language, and strikethroughs.

STATEMENT OF BASIS AND PURPOSE
AND SPECIFIC STATUTORY AUTHORITY
for Amendments to 6 CCR 1009-5 Preparations For A Bioterrorist Event, Pandemic Influenza, Or An Outbreak By A Novel And Highly Fatal Infectious Agent Or Biological Toxin

Basis and Purpose.

The Colorado Department of Public Health and Environment (Department) has the legal authority, established in Colorado law, to adopt rules and to establish standards to assure that hospitals, other acute care facilities, county, district, and municipal public health agencies, and trauma centers are prepared for an emergency epidemic, as defined in section 24-33.5-703 (4).

This emergency rulemaking will formalize the data collection requirements of House Bill 22-1401 (HB 22-1401) and Public Health Order 20-38 (PHO 20-38) so that hospitals will be able to refer to one rule set for a comprehensive understanding of the staffed-bed capacity data and current status for statewide healthcare situational awareness that they are required to report to the Department for emergency preparedness and response purposes.

PHO 20-38 is one of many public health orders issued by the Department during the COVID-19 pandemic. Public health orders are requirements that seek to manage an emergency situation to help keep Coloradans safe during a temporary situation. Public health orders issued during the COVID-19 pandemic set requirements to help prevent the spread of the virus or, in the case of PHO 20-38, provide critical information to the Department as well as local and regional decision-makers. At this point in time, the Department is planning to allow PHO 20-38 to expire at the end of February 2023. As such, the Department is seeking to incorporate specific elements of PHO 20-38 into rule through this emergency rulemaking, as the Department realizes that the value of this information goes beyond the current global pandemic and to the overall preparation and response of the state for future emergencies.

Prior to the COVID-19 pandemic, the Department did not have access to reliable data from healthcare facilities across the state that would allow the Department to determine either a baseline capacity for the normal day-to-day provision of healthcare or the ability to surge during an emergency crisis event. During the early phases of the COVID-19 pandemic, a statewide healthcare reporting platform (EMResource) was developed to provide healthcare facilities with a centralized way to report essential elements of information during the pandemic.

The reporting of these essential elements of information is supported by federal grant requirements through both the Centers for Disease Control and Prevention's Public Health Emergency Preparedness and the Administration for Strategic Preparedness and Response's Hospital Preparedness programs. Both of these federal programs rely on state-level status reports and situational awareness of the state's ability to provide adequate healthcare during a crisis event. Specific examples of the utilization of this data during the COVID-19 pandemic and to maintain future response-ready capacity include the following:

- Determination of Colorado's allocation of the federal Strategic National Stockpile (SNS) ventilator cache and other SNS resources.
- Local, regional, and statewide resource allocation for Colorado's own statewide

medical cache reserves (e.g., personal protective equipment, durable medical equipment, etc.).
- Data-driven emergency triggers or thresholds that support a swift and timely enactment of Governor's executive orders and state or federal disaster declarations.
- Bed capacity and surge data to support the Combined Hospital Transfer Center plan activation for statewide patient transfer and transport load-balancing.
- Real-time snapshots and long-term trend analysis for ongoing planning and prospective modeling, in partnership with Colorado School of Public Health.
- Establishing and monitoring Colorado's baseline day-to-day normal status and function across the healthcare system as compared to response-related surge and shortages.
- Colorado's commitment to build its own state-level healthcare data informatics program that supports but may also be independent of federal requirements.
- Facilitation of acute and post-acute care patient transfers during healthcare surge events.

To ensure that data reporting requirements remain relevant and dynamic for both day-to-day baseline determination as well as response-ready surge, a robust communication feedback network has been maintained to evaluate the relevancy of data fields reported, their corresponding definitions, and reporting frequency. This partnership includes the Colorado Combined Hospital Transfer Center interfacility transfer experts, healthcare emergency management, healthcare coalition stakeholders, and the Colorado Hospital Association. This feedback network supports effective communication and the ability to refine data reporting requirements to lessen, where possible, the burden of reporting on the healthcare facilities impacted by this requirement. During the COVID-19 pandemic, the ability to be flexible in the data reporting requirements provided a dynamic and responsive data system. Future efforts will build upon this proven success.

The consistent and reliable reporting by Colorado healthcare facilities provided a window into the availability of healthcare resources over time. Healthcare reporting metrics were transformed through day-to-day snapshots, as well as long-term trend modeling to provide local, regional, and state public health experts the ability to 1) respond to the pandemic in real-time and 2) to predict and plan for the impact of the pandemic on Colorado's healthcare system. Data were used at all levels of government to determine equitable resource allocations and inform the Colorado Combined Hospital Transfer Center. The Colorado Combined Hospital Transfer Center supports patient movement among rural and urban hospitals and identifies opportunities for patient load-balancing, both of which ensure hospital and post-acute care facilities are able to continue their provision of care.

The value of having hospital-bed capacity data on a regular and ongoing basis is one of the lessons learned through the COVID-19 pandemic. This data was so essential to governmental data-driven decision-making that the Department has determined the data is needed on a permanent basis. This emergency rulemaking seeks to maintain the statewide healthcare reporting platform and centralized hub for healthcare-specific data.

In order to maintain the status quo until permanent rules become effective, hospitals will continue to report their bed capacity to EMResource on Tuesdays and Fridays. Specifically, the proposed language to be moved from PHO 20-38 into this rule includes the following:

- The daily maximum number of adult and pediatric beds that are currently or can be made available within 24 hours for patients in need of ICU level care;

- The daily maximum number of all staffed acute care beds, including ICU beds, available for patients in need of non-ICU hospitalization; and
- The daily maximum number of all adult and pediatric med/surgical beds, available for patients in need of non-ICU hospitalization.

This process and the required data to be reported is 1) consistent with the process used throughout the COVID-19 pandemic and 2) also being discussed and refined with stakeholders for the proposed permanent rulemaking.

Here also, the Department is proposing its third iteration of emergency rules to address mandates created by the passage of HB 22-1401, which was signed into law on May 18, 2022. The new law seeks to ensure hospitals are prepared for a public health emergency or staffing shortage by implementing a robust nurse staffing committee and plan, comprehensive emergency management, and reporting on staffed-bed capacity data to the Department.

To implement HB 22-1401, rules were promulgated into existing rule sets that regulate health facilities across the state (6 CCR 1011-1, Chapter 4, Standards for Hospitals and Health Facilities – General Hospitals). The recently promulgated rule language includes the following:

- Definition of staffed-bed capacity;
- Requirements for hospitals to:
    - Establish a nurse staffing committee that is required to create, implement, and evaluate a nurse staffing plan and to receive, track, and resolve complaints and receive feedback from direct-care nurses and other staff;
    - Submit its nurse staffing plan to the Department on an annual basis;
    - Evaluate its nurse staffing plan on a quarterly basis and, based on complaints and recommendations of patients and staff, revise the nurse staffing plan accordingly;
    - Prepare a quarterly report containing the details of the evaluation;
    - Update its emergency management plans annually and as often as necessary, as circumstances warrant, and include specific provisions to maximize staffed-bed capacity and appropriate utilization of hospital beds to the extent necessary for a public health emergency;
    - Report to the Department the hospital's current staffed-bed capacity, in a form and manner determined by the Department;
    - Notify the Department if the hospital's ability to meet staffed-bed capacity falls below 80% of the required baseline in a specified period, and submit a plan to staff the hospital at 80% or above of its staffed-bed capacity within thirty (30) days; and
    - Assign direct-care providers only to a nursing unit or clinical area of a hospital that the provider is properly trained in; and
- Clarification at Part 7.1(B)(3)(e), to clarify that this requirement applies only to hospitals with more than twenty-five (25) beds.

However, to streamline emergency preparedness requirements into one rule set, the Department proposes moving a portion of these emergency rules into 6 CCR 1009-5, Preparations For A Bioterrorist Event, Pandemic Influenza, Or An Outbreak By A Novel And Highly Fatal Infectious Agent Or Biological Toxin. The proposed rule language to be moved into 6 CCR 1009-5 includes the following:

- The definition of staffed-bed capacity; and

- Requirements for hospitals with more than twenty-five (25) beds to:
    - Report to the Department the hospital's current staffed-bed capacity, in a form and manner determined by the Department;
    - Notify the Department if the hospital's ability to meet staffed-bed capacity falls below 80% of the required baseline in a specified period, and submit a plan to staff the hospital at 80% or above of its staffed-bed capacity within thirty (30) days.

Although requirements of HB 22-1401 have been promulgated through emergency rulemaking, the Department has sought to maintain the required data reporting process for hospital reporting in a manner consistent with that established throughout the entirety of the COVID-19 pandemic. As such, staffed-bed capacity is defined as the total number of acute care beds that hospitals are currently reporting to EMResource[1]. Furthermore, staffed-bed capacity is calculated using the average number of staffed beds reported to the Department in EMResource by the hospital between January 1, 2022, and June 30, 2022. The Department worked with the hospitals to ensure this original number was accurate and adjusted hospital baselines, as needed. The baseline staffed-bed capacity number was calculated for all hospitals required to report, which excludes the following types of hospitals: Licensed rehabilitation hospitals, psychiatric hospitals, hospital units, long-term care hospitals, as defined at 42 U.S.C.1395X(CCC), and specialty hospitals.

The Division of Health Facilities and Emergency Medical Services is also proposing rule amendments that address the remainder of the rule language promulgated in 6 CCR 1011-1, Chapter 4, Standards for Hospitals and Health Facilities – General Hospitals.

In total, in order for the current emergency rules required by HB 22-1401 and those set forth in PHO 20-38 to remain effective while the DCPHR works through its stakeholder engagement process, emergency rules must be adopted by the Board of Health in February 2023.

Emergency rulemaking finding and justification.

An emergency rulemaking, which waives the initial Administrative Procedure Act noticing requirements, is necessary to comply with state law. Emergency rulemaking is authorized pursuant to Section 24-4-103(6), C.R.S. as HB 22-1401 mandates that hospitals establish a nurse staffing committee and begin reporting staffed-bed capacity data to the Department by September 1, 2022, through rules approved by the Board of Health. As the Department continues to work through this detail-intensive stakeholder process, another set of emergency rules is necessary to maintain the status quo and ensure the Department, and all hospitals, are compliant with the requirements of HB 22-1401. Additionally, although PHO 20-38 is set to expire at the end of February 2023, emergency rules are needed to maintain the requirements for bed-capacity reporting across the healthcare system. This data is needed on an ongoing basis and any gaps in reporting, especially during an active respiratory-disease season, could hinder the Department's ability to assess the situation and to respond in real-time.

[1] EMResource is a web-based tool used to assist the state with situational awareness and identification of a facility's and providers' capacity and resource needs.

This emergency rule shall become effective on adoption. It will be effective for no more than 120 days after its adoption unless made permanent through a rulemaking that satisfies the Administrative Procedure Act noticing requirements.

Specific Statutory Authority.
Statutes that require or authorize rulemaking:

Section 25-1-108(1)(c)(VI), C.R.S.

Section 25-3-128, C.R.S.

Other relevant statutes:

Is this rulemaking due to a change in state statute?
__X____ Yes, the bill number is __HB 22-1401_____. Rules are ___ authorized _X__ required.
_____ No
Does this rulemaking include proposed rule language that incorporate materials by reference?
_____ Yes ___ URL
__X____ No

Does this rulemaking include proposed rule language to create or modify fines or fees?
_____ Yes
___X___ No

Does the proposed rule language create (or increase) a state mandate on local government?
_X__ No.
- The proposed rule does not require a local government to perform or increase a specific activity for which the local government will not be reimbursed;
- The proposed rule requires a local government to perform or increase a specific activity because the local government has opted to perform an activity, or;
- The proposed rule reduces or eliminates a state mandate on local government.

___ Yes.

REGULATORY ANALYSIS
for Amendments to 6 CCR 1009-5, Preparations For A Bioterrorist Event, Pandemic Influenza, Or An Outbreak By A Novel And Highly Fatal Infectious Agent Or Biological Toxin

1. A description of the classes of persons affected by the proposed rule, including the classes that will bear the costs and the classes that will benefit from the proposed rule.

Group of persons/entities affected by the proposed rule	Size of the group	Relationship to the proposed rule Select category: C/S/B
Licensed hospitals and hospital units	(109 total)	C
Licensed children's hospitals	3	C
Licensed critical access hospitals	32	C
Licensed hospital units	1	C
Licensed general hospitals	50	C
Licensed long-term care hospitals	6	C
Licensed psychiatric hospitals	9	C
Licensed rehabilitation hospitals	8	C
Patients receiving care at licensed hospitals	Unknown	B

Colorado Hospital Association	101 member hospitals	S

While all are stakeholders, groups of persons/entities connect to the rule and the problem being solved by the rule in different ways. To better understand those different relationships, please use this relationship categorization key:

C = Individuals/entities that implement or apply the rule.
CLG = Local governments that must implement the rule in order to remain in compliance with the law.
S = Individuals/entities that do not implement or apply the rule but are interested in others applying the rule.
B = The individuals that are ultimately served, including the customers of our customers. These individuals may benefit, be harmed by, or be at risk because of the standard communicated in the rule or the manner in which the rule is implemented.

More than one category may be appropriate for some stakeholders.

2. To the extent practicable, a description of the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

Impact on customers (C)

Economic: The impact to each healthcare facility will be different, but there will be administrative and programmatic costs associated with implementing the proposed rules. Additionally, should a hospital fall below the 80% standard for staffed-bed capacity for longer than seven (7) days and does not notify the Department or create a plan of action, then the Department may impose a fine. The Department has authority to assess fees and fines associated with the implementation of House Bill 22-1401 (HB 22-1401). The Department is working with the hospitals through the stakeholder engagement process to determine how to minimize the economic impacts while fulfilling the intent of the legislation.

Non-economic: There may be non-economic administrative, programmatic, and quality improvement costs associated with implementing these proposed rules.

Impact on beneficiaries (B)

Economic: There will not be an economic impact associated with these proposed rules for patients.

Non-economic: The intention of the rule is to ensure hospitals are prepared for a public health emergency or staffing shortage through reporting on bed capacity data to the Department. It is anticipated the Department will use the data reported to them to help

guide decision-making and planning across the healthcare system. The non-economic impacts could include improved access to high-quality healthcare even in times of public health emergency or staffing shortages.

3. The probable costs to the agency and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

A. Anticipated CDPHE personal services, operating costs, or other expenditures:

Type of expenditure	Year 1	Year 2
Reporting platform: EMResource annual cost	227,000	227,000
1 FTE (data monitoring, analysis, hosp plan coordination)	100,000	100,000
Total	327,000	327,000

Anticipated CDPHE Revenues: NA

B. Anticipated personal services, operating costs, or other expenditures by another state agency:

Anticipated Revenues for another state agency: NA

4. A comparison of the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

Along with the costs and benefits discussed above, the proposed revisions:

_X__ Comply with a statutory mandate to promulgate rules.
_X__ Comply with federal or state statutory mandates, federal or state regulations, and department funding obligations.
___ Maintain alignment with other states or national standards.
___ Implement a Regulatory Efficiency Review (rule review) result.
_X__ Improve public and environmental health practice.
_X__ Implement stakeholder feedback.

Advance the following CDPHE Strategic Plan priorities (select all that apply):

1. Reduce Greenhouse Gas (GHG) emissions economy-wide from 125.716 million metric tons of CO2e (carbon dioxide equivalent) per year to 119.430 million metric tons of CO2e per year by June 30, 2020, and to 113.144 million metric tons of CO2e by June 30, 2023.

___ Contributes to the blueprint for pollution reduction.
___ Reduces carbon dioxide from transportation.
___ Reduces methane emissions from oil and gas industry.
___ Reduces carbon dioxide emissions from electricity sector.

2. Reduce ozone from 83 parts per billion (ppb) to 80 ppb by June 30, 2020, and 75 ppb by June 30, 2023.

___ Reduces volatile organic compounds (VOC) and oxides of nitrogen (NOx) from the oil and gas industry.
___ Supports local agencies and COGCC in oil and gas regulations.
___ Reduces VOC and NOx emissions from non-oil and gas contributors

3. Decrease the number of Colorado adults who have obesity by 2,838 by June 30, 2020 and by 12,207 by June 30, 2023.

___ Increases the consumption of healthy food and beverages through education, policy, practice and environmental changes.
___ Increases physical activity by promoting local and state policies to improve active transportation and access to recreation.
___ Increases the reach of the National Diabetes Prevention Program and Diabetes Self-Management Education and Support by collaborating with the Department of Health Care Policy and Financing.

4. Decrease the number of Colorado children (age 2-4 years) who participate in the WIC Program and have obesity from 2120 to 2115 by June 30, 2020 and to 2100 by June 30, 2023.

___ Ensures access to breastfeeding-friendly environments.

5. Reverse the downward trend and increase the percent of kindergartners protected against measles, mumps and rubella (MMR) from 87.4% to 90% (1,669 more kids) by June 30, 2020 and increase to 95% by June 30, 2023.

___ Reverses the downward trend and increase the percent of kindergartners protected against measles, mumps and rubella (MMR) from 87.4% to 90% (1,669 more kids) by June 30, 2020 and increase to 95% by June 30, 2023.
___ Performs targeted programming to increase immunization rates.
___ Supports legislation and policies that promote complete immunization and exemption data in the Colorado Immunization Information System (CIIS).

6. Colorado will reduce the suicide death rate by 5% by June 30, 2020 and 15% by June 30, 2023.

___ Creates a roadmap to address suicide in Colorado.
___ Improves youth connections to school, positive peers and caring adults, and promotes healthy behaviors and positive school climate.
___ Decreases stigma associated with mental health and suicide, and increases help-seeking behaviors among working-age males, particularly within high-risk industries.
___ Saves health care costs by reducing reliance on emergency departments and connects to responsive community-based resources.

7. The Office of Emergency Preparedness and Response (OEPR) will identify 100% of jurisdictional gaps to inform the required work of the Operational Readiness Review by June 30, 2020.

___ Conducts a gap assessment. ___ Updates existing plans to address identified gaps. ___ Develops and conducts various exercises to close gaps.
8. For each identified threat, increase the competency rating from 0% to 54% for outbreak/incident investigation steps by June 30, 2020 and increase to 92% competency rating by June 30, 2023. ___ Uses an assessment tool to measure competency for CDPHE's response to an outbreak or environmental incident. ___ Works cross-departmentally to update and draft plans to address identified gaps noted in the assessment. ___ Conducts exercises to measure and increase performance related to identified gaps in the outbreak or incident response plan.
9. 100% of new technology applications will be virtually available to customers, anytime and anywhere, by June 20, 2020 and 90 of the existing applications by June 30, 2023. ___ Implements the CDPHE Digital Transformation Plan. ___ Optimizes processes prior to digitizing them. ___ Improves data dissemination and interoperability methods and timeliness.
10. Reduce CDPHE's Scope 1 & 2 Greenhouse Gas emissions (GHG) from 6,561 metric tons (in FY2015) to 5,249 metric tons (20% reduction) by June 30, 2020 and 4,593 tons (30% reduction) by June 30, 2023. ___ Reduces emissions from employee commuting ___ Reduces emissions from CDPHE operations
11. Fully implement the roadmap to create and pilot using a budget equity assessment by June 30, 2020 and increase the percent of selected budgets using the equity assessment from 0% to 50% by June 30, 2023. ___ Used a budget equity assessment

_X__ Advance CDPHE Division-level strategic priorities.

The proposed rule aligns with all four strategic planning priorities identified in the CDPHE DCPHR Division Strategic Plan FY 2022 - 2025 to include the following:

1. Achieve operational excellence.
2. Incorporate the learnings of the COVID response across all DCPHR work streams.
3. Continue and increase focus on equity/IDEA (inclusion, diversity, equity, and accessibility) across all DCPHR lines of work.
4. Modernize data systems across all DCPHR.

The proposed rule supports the CDPHE commitment to operational excellence through data-driven decision-making, the incorporation of COVID lessons learned through the enhanced situational awareness that this proposed rule provides, the ability to identify and help

mitigate equity gaps and disparity across the state, whether rural or urban, as well as modernizing data systems by maintaining a reporting platform that remains current and relevant when emergent crises arise.

The costs and benefits of the proposed rule will not be incurred if inaction was chosen. Costs and benefits of inaction not previously discussed include:

HB 22-1401 mandates that hospitals begin reporting to the Department on staffed-bed capacity by September 1, 2022. This emergency rulemaking proposes to maintain existing processes and procedures while the Department continues working closely with stakeholders to develop permanent rules.

5. A determination of whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

Rulemaking is proposed when it is the least costly method or the only statutorily allowable method for achieving the purpose of the statute. The specific revisions proposed in this emergency rulemaking were developed in alignment with the requirements of HB 22-1401, Public Health Order 20-38 (PHO 20-38), and in coordination with the Health Facilities and Emergency Medical Services Division (HFEMS). The proposed regulations are the minimum necessary to maintain initial compliance with the statutory deadline of September 1, 2022.

6. Alternative Rules or Alternatives to Rulemaking Considered and Why Rejected.

The specific revisions proposed in this emergency rulemaking were developed in alignment with the requirements of HB 22-1401, PHO 20-38, and in coordination with the HFEMSD. The proposed regulations are the minimum necessary to maintain initial compliance with the statutory deadline (HB 22-1401) of September 1, 2022.

Furthermore, the proposed rules continue data reporting requirements and processes that have been in place throughout the COVID-19 pandemic. These requirements and processes are the results of an iterative process between the Department and stakeholders.

Federal reporting requirements and data sets, including Health and Human Services Protect and National Healthcare Safety Network data, continue to be evaluated and assessed to prevent duplication in the reporting burden on hospitals. Federal data that meet the Department's criteria for specificity and need will be utilized when appropriate. The Department will continue its effort to streamline reporting definitions and frequency in coordination with hospital reporters, reporting subject matter experts, and federal requirements. The Department's request for information will be based on data precision, timeliness of need, and continuity for baseline and trend analysis.

Maintaining existing requirements and procedures benefits both the Department and the reporters until such time that permanent rules can be promulgated.

7. To the extent practicable, a quantification of the data used in the analysis; the analysis must take into account both short-term and long-term consequences.

The Department used existing EMResource data being reported throughout the COVID-19 pandemic, as well as hospital data on licensed beds and hospital type available to the Department.

The reporting of these essential elements of information is supported by federal grant requirements through both the Centers for Disease Control and Prevention's Public Health Emergency Preparedness and the Administration for Strategic Preparedness and Response's Hospital Preparedness programs that rely on state-level status reports and overarching awareness for the state's ability to provide adequate healthcare during a crisis event.

These data requirements serve to include information that generates situational awareness and a common operating picture for local, regional, and state public health and medical services during a crisis event. Reporting requirements may include evolving incident information, a healthcare facility operating status or structural integrity, evacuation / shelter-in-place operational status, critical medical services and healthcare system status, staffing status, EMS status, and information that allows for resource management decisions to be made based on medical supply caches, partner mutual aid, or deployed state of federal resources.

STAKEHOLDER ENGAGEMENT
for Amendments to 6 CCR 1009-5, Preparations For A Bioterrorist Event, Pandemic Influenza, Or An Outbreak By A Novel And Highly Fatal Infectious Agent Or Biological Toxin

State law requires agencies to establish a representative group of participants when considering to adopt or modify new and existing rules. This is commonly referred to as a stakeholder group.

Early Stakeholder Engagement:
The following individuals and/or entities were invited to provide input and included in the development of these proposed rules:

Organization	**Representative Name and Title (if known)**
Arkansas Valley Regional Medical Center	Heidi Gearhart
Banner Health	Danielle May
	Julia Gentry
	Tracy Hays, Emergency Management
Banner Northern Colorado	Tania Hare
Boulder Community Health	Charlie Mathis
	Chuck Merritt
	Jackie Attlesey-Pries, RN, COO/CNO
	Michele Grulke, ACNO
Centura Health	Andy French
	Bryan Williams
	Kelly Gallant
	Nicole Milo
Children's Hospital Colorado	Donna Pinson
	Ellen Stern, Government Affairs
	Jen Roth
	Kathie Seerup
	Linda Michael
	Lori Claussen
Colorado Department of Human Services, Fort Logan	Ronda K Katzenmeyer
Colorado Department of Public Health and Environment	Alejandra Noa
	Anne Strawbridge
	AnnMarie Harris
	Ash Jackson
	Christina Kemink
	Craig Lee
	Elaine McManis
	Emily Roozen
	Erica Brudjar
	Grace Alford
	Heather Farnsworth

Organization	Representative Name and Title (if known)
	Jaime Yoder
	Jeff Beckman
	Jen Barr
	Jo Tansey
	Kara Johnson-Hufford
	Monica Billig
	Scott Bookman
	Shannon Rossiter
	Shelley Sanderman
Colorado Hospital Association	Bridget Garcia
	Essey Yirdaw
Colorado Mental Health Hospital in Pueblo	Christine Tafoya, Interim CNO
Colorado Mental Health Institute	Katie Cotner, CQO
Colorado Nurses Association	Colleen Casper
	Judith Burke, Retired CNO, Member
	Mary Satre, Board Member
Community Hospital Grand Junction	Benjamin Williams, ACNO
Craig Hospital	Derrek Hidalgo, CNO
	Diane Reinhard
	Julie Negron
CU Anschutz	Stephanie Vega
Delta Health	Dawn Arnett, Director of Med/Surg
	Melissa Palmer, DON
Denver Health	Anne Knudtson, Hospital Compliance
	Emma Paras, Emergency Manager
	Jackie Zheleznyak
	Kathy Boyle, CNO
	Shira Meyerowitz
	Natalie Nicholson
East Morgan County Hospital	Linda Roan
Estes Park Health	Pat Samples
Family Health West Hospital	Britney Guccini
	Travis Dorr
Grand River Health	Melissa Obuhanick
Grandview Hospital	Gretchen Harris, Interim DON
Gunnison Valley Health	Jen Gearhart
	Nicole Huff
Heart of the Rockies Regional Medical Center	April Asbury
	Christine MacMillan
Intermountain Health	Colleen Flack, St. Mary's Hospital
	Geoffrey Hier
	Jamie Refalosells, Director, First Call Command Center
	Collen Flack, St. Mary's Hospital

Organization	Representative Name and Title (if known)
	Tara Buzzitta
	Reagan Goodnight, ACNO, Lutheran Medical Center
	Jeani Frickey Saito
	Sarah Lorenz
Intermountain Peaks Region, St. Mary's	Michelle Shiao
Inverness Rehabilitation Hospital	Brooke Nelson
Keefe Memorial Hospital	Jasmine Shea
Kindred Hospital Denver	Kerri Lowry, CCO
	Mary Corcoran, DNCS
Kiowa County Hospital District	Rachel Bletzacker CNO, FNP-BC
Memorial Regional Health	Olivia Scheele
Middle Park Health	Dani Kloepper, DON, Emergency and Inpatient Services
Montrose Regional Health	Coral Ann Hackett, CNO
	Mary Rasmusson, RN, Director of Education & Emergency Management
Mt. San Rafael Hospital	Calvin Carey
National Jewish Health	Kristi Melton, CNO/Vice-President of Clinical Operations
Pagosa Springs Medical Center	Dan Davis
PAM Specialty Hospital	Dave Hollander, CNO
Parkview Health System	Mandi Smith
Parkview Medical Center	Amelia Vigil
	Andrea Wade
	Kelea Nardini
	Kim Philson, RN-BSN, CMSRN
	Renee Elwell
Parkview Pueblo West	Ruth Baxter
Pioneers Medical Center	Amy Peck, CNO
Prowers Medical Center	Amber Rider
Rangely District Hospital	Makensie Boulger, DON
Reunion Rehabilitation Hospital	Kiera Shaffer
	Laura Dechant
Rio Grande Hospital	Amanda Chapman-Shaw, RN, Clinical Nurse Manager
San Luis Valley Health	Darrick Garcia, Alamosa EMS
	Margaret White, Quality and Safety Director
	Michelle Gay, CHC
	Roberta Bean
SCL Health	Kim de Bruyn Kops
Sedgwick County Health Center	Machelle Newth
Sky Ridge Medical Center	Adam Klatskin
Southeast Colorado Hospital District	Heather Burdick
	Sheri Reed, DON
Spanish Peaks Regional Health Center	Bobbie Trujillo

Organization	Representative Name and Title (if known)
St. Vincent Health	Jana Weiss
Sterling Regional Medical Center	Karalee Anderson, CNO
UCHealth	Cathy O'Brien
	Kathryn Trujillo
	Lisa Camplese, Senior Director, Regulatory Affairs and IP
	Mary Jo Hallaert
	Noreen Bernard, CNO, Longs Peak and Broomfield Hospitals
	Suzanne Golden
	Wendy Sultzman
	Amanda Cobb, Clinical Nurse Director and Colorado Nurse Association Region 2 Director
	Carolyn Carroll Flynn, Capacity Management (South Region)
Vail Health	Amy Lavigne
	Kim Flynn
	Nico Brown
	Ryan Bush
	Sara Dembeck
	William Adochio
Valley View Hospital	Aimee Johnson, Regulatory
	Dawn Sculco, CNO
Wray Community District Hospital	Elena Scarbrough, Director of Quality/Risk Management
	Jennifer Kramer
	Alec Romero
	Ashley Sena
	Ashley Thomas
	Brenda B Simpson
	Colleen Stout
	Colleen Williams
	Dylan Mitchell
	Elaine Gerson
	Jackie Edney
	Jennifer Weibel
	Jessica Short
	Kari Walton
	Kim Philson
	Kristine Cooper
	Kurt Gensert
	Lonnie Martinez
	Lyndsey Olish
	Meg Schroeder
	Melissa Hart

Organization	Representative Name and Title (if known)
	Michelle Kenney

The Health Facilities and Emergency Medical Services Division (HFEMSD) began its stakeholder process in September 2022 and held four (4) virtual stakeholder meetings. The attendance at these meetings was robust. All stakeholder meetings are open to the public, and there has been substantial interest and attendance, as documented in the table above. Meeting information and documents are posted to the Department's Google Drive in advance of each meeting, including draft rules for discussion. All licensed hospitals and interested stakeholders are provided notice of meetings and of alternate methods of providing feedback.

Stakeholder Group Notification

The stakeholder group was provided notice of the rulemaking hearing and provided a copy of the proposed rules or the internet location where the rules may be viewed. Notice was provided prior to the date the notice of rulemaking was published in the Colorado Register (typically, the 10th of the month following the Request for Rulemaking).

__X__ Not applicable. This is an Emergency Rulemaking Packet. Notification will occur if the Board of Health sets this matter for rulemaking.

____ Yes.

Summarize Major Factual and Policy Issues Encountered and the Stakeholder Feedback Received. If there is a lack of consensus regarding the proposed rule, please also identify the Department's efforts to address stakeholder feedback or why the Department was unable to accommodate the request.

This rulemaking is mandated in statute and necessitated by the expiration of Public Health Order 20-38. The Department is proposing language that closely tracks the requirements and processes for data reporting during the COVID-19 pandemic while working with stakeholders to refine the data reporting requirements and processes. The Department is relying on its internal experts, as well as outreach to the hospitals, advocacy groups, and other stakeholders, in order to determine a sustainable process for defining and collecting this data now and into the future.

The Division of Disease Control and Public Health Response (DCPHR) will continue the stakeholder work that began in the HFEMSD. Stakeholders will be able to provide feedback to the Department (specifically DCPHR) through several structured opportunities including a web-based survey and a virtual stakeholder meeting on March 2, 2023.

Please identify the determinants of health or other health equity and environmental justice considerations, values or outcomes related to this rulemaking.

Overall, after considering the benefits, risks and costs, the proposed rule:

Select all that apply.

	Improves behavioral health and mental health; or, reduces substance abuse or suicide risk.	X	Reduces or eliminates health care costs, improves access to health care or the system of care; stabilizes individual participation; or, improves the quality of care for unserved or underserved populations.
	Improves housing, land use, neighborhoods, local infrastructure, community services, built environment, safe physical spaces or transportation.		Reduces occupational hazards; improves an individual's ability to secure or maintain employment; or, increases stability in an employer's workforce.
	Improves access to food and healthy food options.		Reduces exposure to toxins, pollutants, contaminants or hazardous substances; or ensures the safe application of radioactive material or chemicals.
X	Improves access to public and environmental health information; improves the readability of the rule; or, increases the shared understanding of roles and responsibilities, or what occurs under a rule.	X	Supports community partnerships; community planning efforts; community needs for data to inform decisions; community needs to evaluate the effectiveness of its efforts and outcomes.
	Increases a child's ability to participate in early education and educational opportunities through prevention efforts that increase protective factors and decrease risk factors, or stabilizes individual participation in the opportunity.		Considers the value of different lived experiences and the increased opportunity to be effective when services are culturally responsive.
X	Monitors, diagnoses and investigates health problems, and health or environmental hazards in the community.		Ensures a competent public and environmental health workforce or health care workforce.
X	Other:_Complies with Department's obligation to ensure all regulations are consistent with state law._____ _____		Other:_____ _____

COLORADO
Department of Public Health & Environment

TWENTY SIXTH AMENDED PUBLIC HEALTH ORDER 20-38
LIMITED COVID-19 HOSPITAL REPORTING
January 30, 2023

PURPOSE OF THE ORDER

I am issuing this Public Health Order (PHO or Order) in response to the existence of thousands of confirmed and presumptive cases of Coronavirus disease 2019 (COVID-19) and related deaths across the State of Colorado. This Order supersedes PHO 20-36 COVID-19 Dial and PHO 20-29 Voluntary and Elective Surgeries and Procedures, and outlines reporting requirements for hospitals.

FINDINGS

1. On March 10, 2020, Governor Jared Polis verbally declared a disaster emergency regarding COVID-19 in Colorado, and on March 11, 2020 Governor Polis issued **Executive Order D 2020 003**, memorializing the disaster declaration. The Governor's verbal declaration of a disaster emergency is now memorialized in **Executive Order D 2021 122**, as amended and extended by **D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 044, and D 2022 045**. Since that time, the Governor has taken numerous steps to implement measures to mitigate the spread of disease within Colorado, and has further required that several public health orders be issued to implement his orders.

2. As of January 30, 2022, there have been 1,745,322 Coloradans diagnosed with COVID-19, 75,148 have been hospitalized and 14,727 Coloradans have died from COVID-19. There are 185 individuals currently hospitalized due to COVID-19, and 711 hospital beds remain unoccupied across the state. At this time, 88% of Colorado's intensive care beds are occupied and 92% of medical/surgical beds are occupied.

3. CDPHE continues to monitor COVID-19 cases, and in part relies on hospital reporting of cases as well as hospital capacity and resource availability to determine whether any additional measures need to be taken or additional resources are needed to further mitigate disease spread. Individuals are encouraged to get vaccinated and boosted to protect their own health and the health of their communities, as well as reduce their risk of hospitalization for COVID-19.

4. The following additional public health orders remain in effect:

   a. PHO 20-20 Requirements For Colorado Skilled Nursing Facilities, Assisted Living Residences, Intermediate Care Facilities, And Group Homes For COVID-19 Prevention And Response;
   b. PHO 21-01 Vaccine Access And Data Reporting For COVID-19; and
   c. PHO 22-01 Access to Testing and Treatment for COVID-19.

INTENT

This Order includes hospital reporting requirements regarding bed capacity to provide the State with critical information to assess the status of the COVID-19 pandemic relative to the statewide capacity to provide necessary medical care and services to Coloradans.

ORDER

This Order superseded and replaced Public Health Orders 20-29 and 20-36, as amended, on April 16, 2021.

I. COVID-19 RESTRICTIONS

A. Repealed.

B. Repealed.

C. SCHOOLS

1. In accordance with existing law, **Schools** shall report all COVID-19 cases and outbreaks to public health, and work with their local public health agencies and CDPHE, as applicable, regarding COVID-19 case investigations, which includes following all quarantine, isolation, investigation, and any other disease mitigation strategies deemed necessary by the public health agency.

D. Repealed.

E. Repealed.

F. Repealed.

II. HOSPITAL FACILITY REPORTING

A. COVID-19 Case Reporting. All Colorado hospitals shall report to CDPHE in a form and format determined by CDPHE, certain information for confirmed (positive laboratory test) cases of COVID-19, including but not limited to:

1. race and ethnicity;
2. numbers of suspected and confirmed cases who are hospitalized, who are hospitalized and using a ventilator, or who are in the emergency department waiting for an inpatient bed;
3. REPEALED;
4. deaths due to COVID-19;
5. medical equipment and supply information, including but not limited to acute care bed, med/surgical bed, and intensive care unit (ICU) bed capacity and occupancy, and
6. COVID-19 vaccination status, including primary, additional and booster doses, and age.

Reporting by hospitals shall be done in CDPHE's EMResource reporting system twice per week on Tuesday and Friday by 10:00 a.m., or as otherwise required by this Order. Reporting via the COVID Patient Hospital Surveillance system (COPHS) shall continue as instructed by CDPHE.

B. Hospital Bed Capacity Reporting. All Colorado hospitals shall report to CDPHE the following in EMResource twice per week on Tuesday and Friday, by 10:00 a.m.:

1. The daily maximum number of adult and pediatric beds that are currently or can be made available within 24 hours for patients in need of ICU level care; and
2. The daily maximum number of all staffed acute care beds, including ICU beds, available for patients in need of non-ICU hospitalization.
3. The daily maximum number of all adult and pediatric med/surgical beds, available for patients in need of non-ICU hospitalization.

III. Repealed.

IV. Repealed.

V. ENFORCEMENT

This Order will be enforced by all appropriate legal means. Local authorities are encouraged to determine the best course of action to encourage maximum compliance. Failure to comply with

this order could result in penalties, including jail time, and fines, and may also be subject to discipline on a professional license based upon the applicable practice act.

VI. SEVERABILITY

If any provision of this Order or the application thereof to any person or circumstance is held to be invalid, the remainder of the Order, including the application of such part or provision to other persons or circumstances, shall not be affected and shall continue in full force and effect. To this end, the provisions of this Order are severable.

VII. DURATION

This Order shall become effective on Sunday, January 30, 2022 and will expire at 12:01 AM on March 1, 2023 unless extended, rescinded, superseded, or amended in writing.

Jill Hunsaker Ryan, MPH
Executive Director

January 30, 2023
Date

HOUSE BILL 22-1401

BY REPRESENTATIVE(S) Mullica, Amabile, Bernett, Caraveo, Duran, Esgar, Herod, Hooton, Jodeh, Lindsay, Lontine, Ortiz, Sirota, Valdez A.; also SENATOR(S) Moreno, Buckner, Fields, Gonzales, Hinrichsen, Jaquez Lewis, Lee, Pettersen, Story, Winter, Fenberg.

CONCERNING THE PREPAREDNESS OF HEALTH FACILITIES TO MEET PATIENT NEEDS, AND, IN CONNECTION THEREWITH, MAKING AN APPROPRIATION.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. In Colorado Revised Statutes, **add** 25-3-128 and 25-3-129 as follows:

25-3-128. Hospitals - nurses, nurse aides, and EMS providers - staffing requirements - enforcement - waiver - rules - definitions. (1) AS USED IN THIS SECTION:

(a) "CLINICAL STAFF NURSE" MEANS A PRACTICAL NURSE OR REGISTERED PROFESSIONAL NURSE LICENSED PURSUANT TO ARTICLE 255 OF TITLE 12 WHO PROVIDES DIRECT CARE TO PATIENTS.

Capital letters or bold & italic numbers indicate new material added to existing law; dashes through words or numbers indicate deletions from existing law and such material is not part of the act.

(b) "EMS PROVIDER" MEANS AN INDIVIDUAL WHO HOLDS A VALID CERTIFICATE OR LICENSE ISSUED BY THE DEPARTMENT AS PROVIDED IN ARTICLE 3.5 OF THIS TITLE 25.

(c) "NURSE AIDE" MEANS A PERSON CERTIFIED PURSUANT TO ARTICLE 255 OF TITLE 12 TO PRACTICE AS A NURSE AIDE WHO PROVIDES DIRECT CARE TO PATIENTS OR WHO WORKS IN AN AUXILIARY CAPACITY UNDER THE SUPERVISION OF A REGISTERED NURSE.

(d) "STAFFING PLAN" MEANS THE MASTER NURSE STAFFING PLAN DEVELOPED FOR A HOSPITAL PURSUANT TO SUBSECTION (2)(b) OF THIS SECTION.

(2) (a) ON OR BEFORE SEPTEMBER 1, 2022, EACH HOSPITAL SHALL ESTABLISH A NURSE STAFFING COMMITTEE PURSUANT TO RULES PROMULGATED BY THE STATE BOARD OF HEALTH, EITHER BY CREATING A NEW COMMITTEE OR ASSIGNING THE NURSE STAFFING FUNCTIONS TO AN EXISTING HOSPITAL STAFFING COMMITTEE. THE NURSE STAFFING COMMITTEE MUST HAVE AT LEAST SIXTY PERCENT OR GREATER PARTICIPATION BY CLINICAL STAFF NURSES, IN ADDITION TO AUXILIARY PERSONNEL AND NURSE MANAGERS. THE NURSE STAFFING COMMITTEE MUST INCLUDE A DESIGNATED LEADER OF WORKPLACE VIOLENCE PREVENTION AND REDUCTION EFFORTS.

(b) THE NURSE STAFFING COMMITTEE:

(I) SHALL ANNUALLY DEVELOP AND OVERSEE A MASTER NURSE STAFFING PLAN FOR THE HOSPITAL THAT:

(A) IS VOTED ON AND RECOMMENDED BY AT LEAST SIXTY PERCENT OF THE NURSE STAFFING COMMITTEE;

(B) INCLUDES MINIMUM STAFFING REQUIREMENTS AS ESTABLISHED IN RULES PROMULGATED BY THE STATE BOARD OF HEALTH FOR EACH INPATIENT UNIT AND EMERGENCY DEPARTMENT THAT ARE ALIGNED WITH NATIONALLY RECOGNIZED STANDARDS AND GUIDELINES;

(C) INCLUDES STRATEGIES THAT PROMOTE THE HEALTH, SAFETY, AND WELFARE OF THE HOSPITAL'S EMPLOYEES AND PATIENTS;

(D) INCLUDES GUIDANCE AND A PROCESS FOR REDUCING

NURSE-TO-PATIENT ASSIGNMENTS TO ALIGN WITH THE DEMAND BASED ON PATIENT ACUITY; AND

(E) MAY INCLUDE INNOVATIVE STAFFING MODELS;

(II) (A) SHALL SUBMIT THE RECOMMENDED STAFFING PLAN TO THE HOSPITAL'S SENIOR NURSE EXECUTIVE AND THE HOSPITAL'S GOVERNING BODY FOR APPROVAL. IF THE FINAL PLAN APPROVED BY THE HOSPITAL CHANGES MATERIALLY FROM THE RECOMMENDATIONS PUT FORTH BY THE STAFFING COMMITTEE, THE SENIOR NURSE EXECUTIVE SHALL PROVIDE THE NURSE STAFFING COMMITTEE WITH AN EXPLANATION FOR THE CHANGES.

(B) IF, AFTER RECEIVING THE EXPLANATION REFERENCED IN SUBSECTION (2)(b)(II)(A) OF THIS SECTION, THE STAFFING COMMITTEE BELIEVES THE FINAL PLAN DOES NOT MEET NURSE STAFFING STANDARDS ESTABLISHED IN RULES PROMULGATED BY THE STATE BOARD OF HEALTH, THE STAFFING COMMITTEE, WITH A VOTE OF SIXTY PERCENT OR MORE OF THE MEMBERS, MAY REQUEST THE DEPARTMENT REVIEW THE FINAL ADOPTED STAFFING PLAN FOR COMPLIANCE WITH RULES PROMULGATED BY THE STATE BOARD OF HEALTH.

(III) MAY PUBLISH A REPORT THAT IS RESPONSIVE TO THE CHANGES MADE TO THE RECOMMENDED PLAN PURSUANT TO SUBSECTION (2)(b)(II) OF THIS SECTION, IF ANY;

(IV) SHALL DESCRIBE IN WRITING THE PROCESS FOR RECEIVING, TRACKING, AND RESOLVING COMPLAINTS AND RECEIVING FEEDBACK ON THE STAFFING PLAN FROM CLINICAL STAFF NURSES AND OTHER STAFF; AND

(V) SHALL MAKE THE COMPLAINT AND FEEDBACK PROCESS AVAILABLE TO ALL PROVIDERS, INCLUDING CLINICAL STAFF NURSES, NURSE AIDES, AND EMS PROVIDERS.

(c) THE DEPARTMENT IS AUTHORIZED TO AND SHALL ENTER, SURVEY, AND INVESTIGATE EACH HOSPITAL AS NECESSARY TO ENSURE COMPLIANCE WITH THE NURSING STAFFING STANDARDS ESTABLISHED IN RULES PROMULGATED BY THE STATE BOARD OF HEALTH.

(3) A HOSPITAL SHALL:

(a) SUBMIT THE FINAL, APPROVED NURSE STAFFING PLAN TO THE DEPARTMENT ON AN ANNUAL BASIS;

(b) ON A QUARTERLY BASIS, EVALUATE THE STAFFING PLAN AND PREPARE A REPORT FOR INTERNAL REVIEW BY THE STAFFING COMMITTEE;

(c) PROVIDE THE RELEVANT UNIT-BASED STAFFING PLAN TO:

(I) EACH APPLICANT FOR A NURSING POSITION ON A GIVEN UNIT UPON AN OFFER OF EMPLOYMENT; AND

(II) A PATIENT UPON REQUEST; AND

(d) PREPARE AN ANNUAL REPORT CONTAINING THE DETAILS OF THE EVALUATION REQUIRED IN SUBSECTION (3)(b) OF THIS SECTION AND SUBMIT THE REPORT TO THE DEPARTMENT, IN A FORM AND MANNER DETERMINED BY RULES PROMULGATED BY THE STATE BOARD OF HEALTH.

(4) A HOSPITAL SHALL NOT ASSIGN A CLINICAL STAFF NURSE, NURSE AIDE, OR EMS PROVIDER TO A HOSPITAL UNIT UNLESS, CONSISTENT WITH THE CONDITIONS OF PARTICIPATION ADOPTED FOR FEDERAL MEDICARE AND MEDICAID PROGRAMS, HOSPITAL PERSONNEL RECORDS INCLUDE DOCUMENTATION THAT THE TRAINING AND DEMONSTRATION OF COMPETENCY WERE SUCCESSFULLY COMPLETED DURING ORIENTATION AND ON A PERIODIC BASIS CONSISTENT WITH HOSPITAL POLICIES.

(5) (a) ON OR BEFORE SEPTEMBER 1, 2022, EACH HOSPITAL SHALL REPORT, IN A FORM AND MANNER DETERMINED BY RULES PROMULGATED BY THE STATE BOARD OF HEALTH, THE BASELINE NUMBER OF BEDS THE HOSPITAL IS ABLE TO STAFF IN ORDER TO PROVIDE PATIENT CARE AND THE HOSPITAL'S CURRENT BED CAPACITY. THE REPORTING MAY INCLUDE:

(I) SEASONAL OR OTHER ANTICIPATED VARIANCES IN STAFFED-BED CAPACITY; AND

(II) ANTICIPATED FACTORS IMPACTING STAFFED-BED CAPACITY.

(b) IN PROMULGATING RULES PURSUANT TO SUBSECTION (5)(a) OF THIS SECTION, THE STATE BOARD OF HEALTH SHALL:

(I) USE THE DATA PROVIDED TO THE DEPARTMENT BY EACH HOSPITAL THROUGHOUT THE COVID-19 PANDEMIC THROUGH AN INTERNET-BASED RESOURCE MANAGEMENT AND COMMUNICATION TOOL DEVELOPED FOR AND COMMONLY USED BY HOSPITALS;

(II) DETERMINE THE NUMBER OF SEASONAL VARIATIONS ALLOWABLE WITH REGARD TO SUBSECTION (5)(a)(I) OF THIS SECTION WITH A MINIMUM OF TWO AND A MAXIMUM OF FOUR ALLOWABLE VARIANCES; AND

(III) DEFINE "STAFFED-BED CAPACITY" FOR THE PURPOSES OF THIS SECTION.

(c) ON OR BEFORE SEPTEMBER 1, 2022, AS DETERMINED BY RULES PROMULGATED BY THE STATE BOARD OF HEALTH, IF A HOSPITAL'S ABILITY TO MEET STAFFED-BED CAPACITY FALLS BELOW EIGHTY PERCENT OF THE HOSPITAL'S REPORTED BASELINE FOR NOT LESS THAN SEVEN AND NOT MORE THAN FOURTEEN CONSECUTIVE DAYS, THE HOSPITAL SHALL NOTIFY THE DEPARTMENT AND SUBMIT:

(I) A PLAN TO ENSURE STAFF IS AVAILABLE, WITHIN THIRTY DAYS, TO RETURN TO A STAFFED-BED CAPACITY LEVEL THAT IS EIGHTY PERCENT OF THE REPORTED BASELINE; OR

(II) A REQUEST FOR A WAIVER DUE TO A HARDSHIP, WHICH REQUEST ARTICULATES WHY THE HOSPITAL IS UNABLE TO MEET THE REQUIRED STAFFED-BED CAPACITY IF:

(A) THE HOSPITAL'S CURRENT STAFFED-BED CAPACITY FALLS BELOW EIGHTY PERCENT OF THE HOSPITAL'S REPORTED BASELINE FOR NOT LESS THAN SEVEN AND NOT MORE THAN FOURTEEN CONSECUTIVE DAYS; OR

(B) THE HOSPITAL'S CURRENT STAFFED-BED CAPACITY THREATENS PUBLIC HEALTH.

(d) THE DEPARTMENT MAY IMPOSE FINES, NOT TO EXCEED ONE THOUSAND DOLLARS PER DAY, FOR A HOSPITAL'S FAILURE TO:

(I) MEET THE REPORTED STAFFED-BED CAPACITY OF EIGHTY PERCENT OR MORE OF THE HOSPITAL'S REPORTED BASELINE; OR

(II) ACCURATELY REPORT A HOSPITAL'S BASELINE STAFFED-BED CAPACITY.

(6) EACH HOSPITAL WITH MORE THAN TWENTY-FIVE BEDS SHALL ARTICULATE IN ITS EMERGENCY PLAN A DEMONSTRATED ABILITY TO EXPAND THE HOSPITAL'S STAFFED-BED CAPACITY UP TO ONE HUNDRED TWENTY-FIVE PERCENT OF THE HOSPITAL'S BASELINE STAFFED-BED CAPACITY AND INTENSIVE CARE UNIT CAPACITY WITHIN FOURTEEN DAYS AFTER:

(a) A STATEWIDE PUBLIC HEALTH EMERGENCY IS DECLARED OR THE HOSPITAL IS NOTIFIED BY THE DEPARTMENT THAT SURGE CAPACITY IS NEEDED; AND

(b) THE STATE HAS USED ALL AVAILABLE AUTHORITY TO EXPEDITE WORKFORCE AVAILABILITY AND MAXIMIZE HOSPITAL THROUGHPUT AND CAPACITY, SUCH AS:

(I) LICENSING OR CERTIFICATION FLEXIBILITY FOR HEALTH FACILITIES;

(II) REDUCING REQUIREMENTS FOR LICENSING, CREDENTIALING, AND THE RECEIPT OF STAFF PRIVILEGES;

(III) WAIVING SCOPE OF PRACTICE LIMITATIONS; AND

(IV) WAIVING STATE-REGULATED PAYER PROVISIONS THAT CREATE BARRIERS TO TIMELY PATIENT DISCHARGE.

(7) EACH HOSPITAL SHALL UPDATE ITS EMERGENCY PLAN AT LEAST ANNUALLY AND AS OFTEN AS NECESSARY, AS CIRCUMSTANCES WARRANT. THE EMERGENCY PLAN MUST INCLUDE THE ACTIONS THE HOSPITAL WILL TAKE TO MAXIMIZE STAFFED-BED CAPACITY AND APPROPRIATE UTILIZATION OF HOSPITAL BEDS TO THE EXTENT NECESSARY FOR A PUBLIC HEALTH EMERGENCY AND THROUGH THE FOLLOWING ACTIVITIES:

(a) CROSS-TRAINING, JUST-IN-TIME TRAINING, AND REDEPLOYMENT OF STAFF;

(b) SUPPORTING ALL HOSPITAL FACILITIES, INCLUDING HOSPITAL-OWNED FACILITIES, TO PROVIDE ANY NECESSARY, AVAILABLE,

AND APPROPRIATE PREVENTIVE CARE, VACCINE ADMINISTRATION, DIAGNOSTIC TESTING, AND THERAPEUTICS;

(c) MAXIMIZING HOSPITAL THROUGHPUT BY DISCHARGING PATIENTS TO SKILLED NURSING, POST-ACUTE, AND OTHER STEP-DOWN FACILITIES; AND

(d) REDUCING THE NUMBER OF SCHEDULED PROCEDURES IN THE HOSPITAL.

(8) BEGINNING SEPTEMBER 1, 2022, THE DEPARTMENT MAY FINE A HOSPITAL AN AMOUNT NOT TO EXCEED TEN THOUSAND DOLLARS PER DAY FOR THE FAILURE TO:

(a) ACHIEVE THE REQUIRED STAFFED-BED CAPACITY DESCRIBED IN SUBSECTION (6) OF THIS SECTION WITHIN FOURTEEN DAYS AFTER A DECLARED STATEWIDE PUBLIC HEALTH EMERGENCY OR OTHER NOTIFICATION BY THE DEPARTMENT THAT SURGE CAPACITY IS NEEDED;

(b) INCLUDE THE AMOUNT OF NECESSARY VACCINES FOR ADMINISTRATION IN ITS ANNUAL EMERGENCY PLAN AND HAVE THE VACCINES AVAILABLE, TO THE EXTENT THAT THE VACCINES ARE AVAILABLE, AT EACH OF ITS HOSPITAL FACILITIES AND HOSPITAL-OWNED PRIMARY CARE SITES DURING AND OUTSIDE OF THE PUBLIC HEALTH EMERGENCY, AS DETERMINED BY RULES PROMULGATED BY THE DEPARTMENT; AND

(c) INCLUDE THE NECESSARY TESTING CAPABILITIES AVAILABLE IN ITS ANNUAL EMERGENCY PLAN AND AT EACH OF ITS HOSPITAL FACILITIES AND HOSPITAL-OWNED PRIMARY CARE SITES DURING AND OUTSIDE OF A PUBLIC HEALTH EMERGENCY, TO THE EXTENT THAT THE TESTING IS AVAILABLE, AS DETERMINED BY RULES PROMULGATED BY THE DEPARTMENT.

(9) FOR THE PURPOSES OF THIS SECTION, THE DEPARTMENT SHALL ENTER, SURVEY, AND INVESTIGATE EACH HOSPITAL:

(a) AS DEEMED NECESSARY BY THE DEPARTMENT;

(b) FOR PURPOSES OF INFECTION CONTROL AND EMERGENCY PREPAREDNESS; AND

(c) TO ENSURE COMPLIANCE WITH THIS SECTION.

(10) THE DEPARTMENT SHALL ANNUALLY REPORT ON THE INFORMATION CONTAINED IN THE QUARTERLY REPORT DESCRIBED IN SUBSECTION (3)(d) OF THIS SECTION AS A PART OF ITS PRESENTATION TO ITS COMMITTEE OF REFERENCE AT A HEARING HELD PURSUANT TO SECTION 2-7-203 (2)(a) OF THE "STATE MEASUREMENT FOR ACCOUNTABLE, RESPONSIVE, AND TRANSPARENT (SMART) GOVERNMENT ACT".

(11) THE DEPARTMENT MAY PROMULGATE RULES TO REQUIRE HEALTH FACILITIES LICENSED PURSUANT TO SECTION 25-1.5-103 TO DEVELOP AND IMPLEMENT INFECTION PREVENTION PLANS THAT ALIGN WITH NATIONAL BEST PRACTICES AND STANDARDS AND THAT ARE RESPONSIVE TO COVID-19 AND OTHER COMMUNICABLE DISEASES. THE REQUIREMENTS MAY INCLUDE TESTING, VACCINATION, AND TREATMENT IN ACCORDANCE WITH APPLICABLE STATE LAWS, RULES, AND EXECUTIVE ORDERS.

(12) THE STATE BOARD OF HEALTH SHALL PROMULGATE RULES AS NECESSARY TO IMPLEMENT THIS SECTION.

25-3-129. Office of saving people money on health care - study - report. (1) THE OFFICE OF SAVING PEOPLE MONEY ON HEALTH CARE IN THE LIEUTENANT GOVERNOR'S OFFICE SHALL STUDY:

(a) THE LEVEL OF PREPAREDNESS OF HEALTH FACILITIES LICENSED PURSUANT TO SECTION 25-1.5-103 TO RESPOND TO POST-VIRAL ILLNESS RESULTING FROM THE COVID-19 VIRUS;

(b) THE EFFECTS OF POST-VIRAL ILLNESS RESULTING FROM THE COVID-19 VIRUS ON THE MENTAL, BEHAVIORAL, AND PHYSICAL HEALTH AND THE FINANCIAL SECURITY OF THE PEOPLE OF COLORADO; AND

(c) THE EFFECTS OF THE COVID-19 PANDEMIC ON THE COST OF HEALTH CARE IN COLORADO AND ON THE ABILITY OF COLORADO'S PUBLIC HEALTH SYSTEM TO RESPOND TO EMERGENCIES.

(2) ON OR BEFORE JANUARY 1, 2023, AND ON OR BEFORE JANUARY 1 EACH YEAR THEREAFTER, THE OFFICE OF SAVING PEOPLE MONEY ON HEALTH CARE SHALL REPORT ITS FINDINGS TO THE GOVERNOR.

(3) THE OFFICE OF SAVING PEOPLE MONEY ON HEALTH CARE SHALL COORDINATE, MONITOR, AND SUPPORT THE EFFORTS TO IMPROVE THE

AFFORDABILITY OF HEALTH CARE, HEALTH OUTCOMES, AND PUBLIC HEALTH READINESS IN STATE PROGRAMS AND DEPARTMENTS.

SECTION 2. In Colorado Revised Statutes, 25-1.5-103, **amend** (1)(a)(I)(C) as follows:

25-1.5-103. Health facilities - powers and duties of department - limitations on rules promulgated by department - definitions. (1) The department has, in addition to all other powers and duties imposed upon it by law, the powers and duties provided in this section as follows:

(a) (I) (C) The department shall extend the survey cycle or conduct a tiered inspection or survey of a health facility licensed for at least three years and against which no enforcement activity has been taken, no patterns of deficient practices exist, as documented in the inspection and survey reports issued by the department, and no substantiated complaint resulting in the discovery of significant deficiencies that may negatively affect the life, health, or safety of consumers of the health facility has been received within the three years prior to the date of the inspection. The department may expand the scope of the inspection or survey to an extended or full survey if the department finds deficient practice during the tiered inspection or survey. The department, by rule, shall establish a schedule for an extended survey cycle or a tiered inspection or survey system designed, at a minimum, to: Reduce the time needed for and costs of licensure inspections for both the department and the licensed health facility; reduce the number, frequency, and duration of on-site inspections; reduce the scope of data and information that health facilities are required to submit or provide to the department in connection with the licensure inspection; reduce the amount and scope of duplicative data, reports, and information required to complete the licensure inspection; and be based on a sample of the facility size. Nothing in this ~~sub-subparagraph (C)~~ SUBSECTION (1)(a)(I)(C) limits the ability of the department to conduct a periodic inspection or survey that is required to meet its obligations as a state survey agency on behalf of the FEDERAL centers for medicare and medicaid services or the department of health care policy and financing to assure that the health facility meets the requirements for participation in the medicare and medicaid programs OR LIMITS THE ABILITY OF THE DEPARTMENT TO ENTER, SURVEY, AND INVESTIGATE HOSPITALS PURSUANT TO SECTION 25-3-128.

SECTION 3. In Colorado Revised Statutes, 25-3-102.1, **amend** (1)(b)(II) as follows:

25-3-102.1. Deemed status for certain facilities. (1) (b) (II) If the standards for national accreditation are less stringent than the state's licensure standards for a particular health facility, the department of public health and environment may conduct a survey that focuses on the more stringent state standards. Beginning one year after the department first grants deemed status to a health facility pursuant to this ~~paragraph (b)~~ SUBSECTION (1)(b), the department may conduct validation surveys, based on a valid sample methodology, of up to ten percent of the total number of accredited health facilities in the industry. ~~excluding hospitals.~~ If the department conducts a validation survey of a health facility, the validation survey is in lieu of a licensing renewal survey that the health facility would have undergone if the health facility did not have deemed status pursuant to this ~~paragraph (b)~~ SUBSECTION (1)(b). NOTWITHSTANDING ANY OTHER LAW TO THE CONTRARY, THE DEPARTMENT MAY ENTER, SURVEY, AND INVESTIGATE HOSPITALS PURSUANT TO SECTION 25-3-128.

SECTION 4. In Colorado Revised Statutes, 25-3-105, **amend** (1)(a)(I)(B) and (1)(a)(I)(C) as follows:

25-3-105. License - fee - rules - penalty - repeal. (1) (a) (I) (B) On or after June 4, 2012, the state board of health may increase the amount of any fee on the schedule of fees established pursuant to subsection (1)(a)(I)(A) of this section that is in effect on June 4, 2012, by an amount not to exceed the annual percentage change in the United States department of labor, bureau of labor statistics, consumer price index for Denver-Aurora-Lakewood for all urban consumers and all goods, or its applicable predecessor or successor index. Nothing in this subsection (1)(a)(I)(B) limits the ability of the state board of health to reduce the amount of any fee on the schedule of fees in effect on such date or to modify fees as necessary to comply with section 24-75-402. NOTWITHSTANDING THE REQUIREMENTS OF THIS SUBSECTION (1)(a)(I)(B), THE STATE BOARD OF HEALTH MAY ASSESS FEES NECESSARY TO COVER THE COSTS ASSOCIATED WITH THE SURVEYS CONDUCTED PURSUANT TO SECTION 25-3-128.

(C) The department of public health and environment shall institute, by rule, a performance incentive system for licensed health facilities under

which a licensed health facility would be eligible for a reduction in its license renewal fee if: The department's on-site relicensure inspection demonstrates that the health facility has no significant deficiencies that have negatively affected the life, safety, or health of its consumers; the licensed health facility has fully and timely cooperated with the department during the on-site inspection; the department has found no documented actual or potential harm to consumers; and, in the case where any significant deficiencies are found that do not negatively affect the life, safety, or health of consumers, the licensed health facility has submitted, and the department has accepted, a plan of correction and the health facility has corrected the deficient practice, as verified by the department, within the period required by the department. NOTWITHSTANDING THE REQUIREMENTS OF THIS SUBSECTION (1)(a)(I)(C), ANY FEES ASSOCIATED WITH THE SURVEYS AND INVESTIGATIONS OF HOSPITALS AUTHORIZED BY SECTION 25-3-128 ARE NOT SUBJECT TO A REDUCTION BASED ON THE PERFORMANCE INCENTIVE SYSTEM.

SECTION 5. In Colorado Revised Statutes, **repeal** 25-3-702.

SECTION 6. In Colorado Revised Statutes, 25-3-703, **amend** (1) as follows:

25-3-703. Hospital report card - rules - exemption. (1) (a) The executive director shall approve a Colorado hospital report card consisting of public disclosure of data assembled pursuant to this part 7. At a minimum, the data shall be made available on an internet website in a manner that allows consumers to conduct an interactive search that allows them to view and compare the information for specific hospitals. The website ~~shall~~ MUST include:

(I) CLINICAL OUTCOMES MEASURES FROM GENERAL AND PUBLIC HOSPITALS LICENSED PURSUANT TO SECTION 25-1.5-103; AND

(II) Such additional information as is determined necessary to ensure that the website enhances informed decision making among consumers and health-care purchasers, which ~~shall~~ MUST include, at a minimum, appropriate guidance on how to use the data and an explanation of why the data may vary from hospital to hospital. ~~The data specified in this subsection (1) shall be released on or before November 30, 2007.~~

(b) WHEN MAKING A DETERMINATION AS TO WHAT DATA TO REPORT

AS REQUIRED BY SUBSECTION (1)(a) OF THIS SECTION, EACH EXECUTIVE DIRECTOR SHALL CONSIDER:

(I) INCLUSION OF DATA ON ALL PATIENTS REGARDLESS OF THE PAYER SOURCE FOR COLORADO HOSPITALS AND OTHER INFORMATION THAT MAY BE REQUIRED FOR EITHER INDIVIDUAL OR GROUP PURCHASERS TO ASSESS THE VALUE OF THE PRODUCT;

(II) USE OF STANDARDIZED CLINICAL OUTCOMES MEASURES RECOGNIZED BY NATIONAL ORGANIZATIONS THAT ESTABLISH STANDARDS TO MEASURE THE PERFORMANCE OF HEALTH-CARE PROVIDERS;

(III) DATA THAT IS SEVERITY AND ACUITY ADJUSTED USING STATISTICAL METHODS THAT SHOW VARIATION IN REPORTED OUTCOMES, WHERE APPLICABLE, AND DATA THAT HAS PASSED STANDARD EDITS;

(IV) REPORTING THE RESULTS WITH SEPARATE DOCUMENTS CONTAINING THE TECHNICAL SPECIFICATION AND MEASURES;

(V) STANDARDIZATION IN REPORTING; AND

(VI) DISCLOSURE OF THE METHODOLOGY OF REPORTING.

SECTION 7. In Colorado Revised Statutes, 25-3-703, **add** (3) and (4) as follows:

25-3-703. Hospital report card - rules - exemption. (3) THE STATE BOARD OF HEALTH SHALL PROMULGATE RULES THAT ESTABLISH NURSING-SENSITIVE QUALITY MEASURES BASED UPON A NATIONALLY RECOGNIZED STANDARD AND REVISE THE RULES AS NECESSARY EVERY THREE YEARS TO BE INCLUDED IN THE HOSPITAL REPORT CARD. THE NURSING-SENSITIVE QUALITY MEASURES MUST INCLUDE AT A MINIMUM:

(a) SKILL MIX;

(b) THE NURSING HOURS PER PATIENT PER DAY;

(c) VOLUNTARY TURNOVER;

(d) PATIENT FALLS PREVALENCE RATE;

(e) PATIENT FALLS WITH INJURY; AND

(f) RECORDED INCIDENCES OF VIOLENCE AGAINST STAFF AND CONTRACTED STAFF.

(4) HOSPITALS WITH FEWER THAN ONE HUNDRED BEDS ARE EXEMPT FROM THE REQUIREMENTS OF THIS SECTION.

SECTION 8. In Colorado Revised Statutes, 25-3-705, **amend** (1) as follows:

25-3-705. Health-care charge transparency - hospital charge report. (1) The commissioner of insurance shall work with the duly constituted association of hospitals selected by the executive director ~~pursuant to section 25-3-702~~ for assistance in carrying out the purposes of this section.

SECTION 9. Appropriation. (1) For the 2022-23 state fiscal year, $645,340 is appropriated to the department of public health and environment for use by the health facilities and emergency management services division. This appropriation is from the general fund and is based on an assumption that the division will require an additional 6.2 FTE. To implement this act, the division may use this appropriation for the nursing and acute care facility survey.

(2) For the 2022-23 state fiscal year, $139,939 is appropriated to the office of the governor. This appropriation is from the general fund and is based on an assumption that the office will require an additional 0.9 FTE. To implement this act, the office may use this appropriation for the administration of governor's office and residence.

SECTION 10. Safety clause. The general assembly hereby finds,

determines, and declares that this act is necessary for the immediate preservation of the public peace, health, or safety.

Alec Garnett
SPEAKER OF THE HOUSE
OF REPRESENTATIVES

Steve Fenberg
PRESIDENT OF
THE SENATE

Robin Jones
CHIEF CLERK OF THE HOUSE
OF REPRESENTATIVES

Cindi L. Markwell
SECRETARY OF
THE SENATE

APPROVED May 18th at 12:42 pm
(Date and Time)

Jared S. Polis
GOVERNOR OF THE STATE OF COLORADO

6 CCR 1009-5 PREPARATIONS FOR A BIOTERRORIST EVENT, PANDEMIC INFLUENZA, OR AN OUTBREAK BY A NOVEL AND HIGHLY FATAL INFECTIOUS AGENT OR BIOLOGICAL TOXIN

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Regulation 2. Preparations by General or Critical Access Hospitals for ENHANCED SITUATIONAL AWARENESS, EMERGENCY PREPAREDNESS, AND EMERGENCY RESPONSE ~~an Emergency Epidemic~~

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4. MANDATORY HOSPITAL REPORTING

A) "STAFFED-BED CAPACITY" MEANS THE TOTAL NUMBER OF ALL STAFFED ACUTE CARE INPATIENT BEDS.

i) FOR PURPOSES OF THIS DEFINITION, "STAFFED" MEANS A BED, IN AN INPATIENT UNIT, THAT A FACILITY CAN STAFF WITH THE APPROPRIATE PERSONNEL, IN ACCORDANCE WITH THE FACILITY'S UNIT-SPECIFIC NURSE STAFFING PLAN.

ii) ACUTE CARE BEDS INCLUDED IN THIS COUNT MAY INCLUDE:

(a) INTENSIVE CARE UNIT (ICU);

(b) PROGRESSIVE CARE UNIT (PCU)/STEPDOWN;

(c) MED/SURG./TELE;

(d) SURGE/OVERFLOW;

B) CERTIFIED CRITICAL ACCESS HOSPITALS (CAHS) SHALL NOT INCLUDE SWING BEDS IN ITS STAFFED-BED CAPACITY.

C) THE MANDATORY HOSPITAL REPORTING REQUIREMENTS DETAILED IN THIS RULE DO NOT APPLY TO LICENSED REHABILITATION HOSPITALS, PSYCHIATRIC HOSPITALS, HOSPITAL UNITS, LONG-TERM CARE HOSPITALS, AS DEFINED AT 42 U.S.C. 1395X(CCC), AND SPECIALTY HOSPITALS.

D) CALCULATING STAFFED BED CAPACITY - BEGINNING SEPTEMBER 1,

2022, A HOSPITAL'S BASELINE STAFFED-BED CAPACITY SHALL BE CALCULATED USING THE AVERAGE NUMBER OF STAFFED BEDS REPORTED TO THE DEPARTMENT BY THE HOSPITAL BETWEEN JANUARY 1, 2022, AND JUNE 30, 2022.

(i) THE HOSPITAL'S BASELINE STAFFED-BED CAPACITY SHALL BE COMMUNICATED TO THE HOSPITAL IN A FORM AND MANNER DETERMINED BY THE DEPARTMENT.

(ii) A HOSPITAL SHALL HAVE THIRTY (30) DAYS FROM NOTIFICATION OF ITS BASELINE STAFFED-BED CAPACITY TO CONTACT THE DEPARTMENT AND REQUEST A RECALCULATION OF ITS BASELINE STAFFED-BED CAPACITY.

(a) THE HOSPITAL SHALL SUBMIT SUPPORTING DATA AND OTHER INFORMATION IN A FORM AND MANNER DETERMINED BY THE DEPARTMENT.

(iii) ONCE INITIALLY ESTABLISHED, THE HOSPITAL'S BASELINE STAFFED-BED CAPACITY MAY BE RECALCULATED ANNUALLY.

(a) THE HOSPITAL SHALL ARTICULATE IN ITS EMERGENCY MANAGEMENT PLAN, AS SET FORTH IN 6 CCR 1011-1, CHAPTER 4, A PROCESS FOR RECALCULATING THE HOSPITAL'S ORIGINAL BASELINE STAFFED-BED CAPACITY. SUCH RECALCULATION MAY BE AN ANNUAL RECALCULATION, BE BASED ON THE HOSPITAL'S ADJUSTMENT FOR A MINIMUM OF 2 AND A MAXIMUM OF 4 SEASONAL VARIANCES, AND/OR BASED ON OTHER ANTICIPATED FACTORS AFFECTING STAFFED-BED CAPACITY.

E) REQUIRED REPORTING - STAFFED-BED CAPACITY

(i) EACH HOSPITAL SHALL REPORT ITS CURRENT STAFFED-BED CAPACITY, IN THE FORM AND MANNER DETERMINED BY THE DEPARTMENT.

(ii) IF A HOSPITAL'S ABILITY TO MEET STAFFED-BED CAPACITY FALLS BELOW EIGHTY (80) PERCENT OF THE HOSPITAL'S REPORTED BASELINE FOR NO LESS THAN SEVEN (7) AND NO MORE THAN FOURTEEN (14) CONSECUTIVE DAYS, THE HOSPITAL SHALL NOTIFY THE DEPARTMENT AND SUBMIT THE FOLLOWING:

(a) A PLAN TO ENSURE STAFF IS AVAILABLE, WITHIN THIRTY

(30) DAYS, TO RETURN TO A STAFFED-BED CAPACITY LEVEL THAT IS EIGHTY (80) PERCENT OF THE REPORTED BASELINE; OR

(b) A REQUEST FOR A WAIVER DUE TO A HARDSHIP, WHICH REQUEST ARTICULATES WHY THE HOSPITAL IS UNABLE TO MEET THE REQUIRED STAFFED-BED CAPACITY IF:

(1) THE HOSPITAL'S CURRENT STAFFED-BED CAPACITY FALLS BELOW EIGHTY (80) PERCENT OF THE HOSPITAL'S REPORTED BASELINE FOR NO LESS THAN SEVEN (7) AND NO MORE THAN FOURTEEN (14) CONSECUTIVE DAYS, OR

(2) THE HOSPITALS' CURRENT STAFFED-BED CAPACITY THREATENS PUBLIC HEALTH.

F. REQUIRED REPORTING - ADDITIONAL DATA - IN ADDITION TO THE REPORTING STAFFED BED CAPACITY, ALL LICENSED HEALTH FACILITIES ARE REQUIRED TO REPORT ANY DATA DEEMED NECESSARY FOR SITUATIONAL AWARENESS AND EMERGENCY PREPAREDNESS AND RESPONSE, INCLUDING:

i. THE DAILY MAXIMUM NUMBER OF ADULT AND PEDIATRIC BEDS THAT ARE CURRENTLY OR CAN BE MADE AVAILABLE WITHIN 24 HOURS FOR PATIENTS IN NEED OF INTENSIVE CARE UNIT LEVEL CARE. REPORTING SHALL BE MADE IN THE FORM AND MANNER DETERMINED BY THE DEPARTMENT.

ii. THE DAILY MAXIMUM NUMBER OF ALL STAFFED ACUTE CARE BEDS, INCLUDING INTENSIVE CARE UNIT BEDS, AVAILABLE FOR PATIENTS IN NEED OF NON-INTENSIVE CARE UNIT HOSPITALIZATION. REPORTING SHALL BE MADE IN THE FORM AND MANNER DETERMINED BY THE DEPARTMENT.

iii. THE DAILY MAXIMUM NUMBER OF ALL ADULT AND PEDIATRIC MED/SURGICAL BEDS, AVAILABLE FOR PATIENTS IN NEED OF NON-INTENSIVE CARE UNIT HOSPITALIZATION. REPORTING SHALL BE MADE IN THE FORM AND MANNER DETERMINED BY THE DEPARTMENT.

iv. THE DEPARTMENT MAY REQUIRE ADDITIONAL CRISIS-SPECIFIC

REPORTING AS NECESSARY FOR SITUATIONAL AWARENESS OR FOR EMERGENCY PREPAREDNESS, AND RESPONSE PURPOSES ON AN ONGOING BASIS.

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G. SURGE CAPACITY REPORTING

(i) EACH HOSPITAL WITH MORE THAN TWENTY-FIVE (25) BEDS SHALL ARTICULATE IN ITS EMERGENCY MANAGEMENT PLAN A DEMONSTRATED ABILITY TO EXPAND THE HOSPITAL'S STAFFED-BED CAPACITY IN COMPLIANCE WITH REGULATIONS SET FORTH IN 6 CCR 1011-1, CHAPTER 4.

H. ANY HOSPITAL THAT FAILS TO COMPLY WITH THESE REQUIREMENTS SHALL BE SUBJECT TO ENFORCEMENT BY THE DEPARTMENT PURSUANT TO 6 CCR 1011-1, CHAPTER 2 AND CHAPTER 4, AND SECTION 25-3-128(5)(D), C.R.S.

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